

**THE SPECTRUM OF OCCUPATIONAL
RESOURCES FOR ADULTS WITH
PSYCHIATRIC DISABILITIES
IN MANITOBA:
A DISCUSSION PAPER**

**SUBMITTED TO THE MENTAL HEALTH DIVISION
OF MANITOBA HEALTH BY:**

**THE WORKING GROUP ON THE SPECTRUM OF
OCCUPATIONAL RESOURCES FOR INDIVIDUALS
WITH PSYCHIATRIC DISABILITIES**

MAY, 1991



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**Submitted To The Mental Health
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of Occupational Resources For
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EXECUTIVE SUMMARY

In the last decade in North America, significant changes and trends have developed in the areas of employment, education and recreation for adults with psychiatric disabilities. For example, developments have occurred in consumer empowerment, psychiatric rehabilitation, employment and educational opportunities, nonfacility based programming and ongoing support that are tailored to individual needs. Central to these changes is the shift from the primary role of client/service recipient to the life roles of worker, student, leisure participant, etc.

Occupational resources (ie. employment, education and recreation) for Manitobans with psychiatric disabilities have received little attention in the past and this has resulted in an underdeveloped, poorly coordinated array of resources. By and large, most resources have retained traditional program concepts and have not incorporated the new trends and findings that are supported in the current literature.

In light of the new directions in mental health that were established in November, 1988, by The Minister of Health, The Honourable Donald W. Orchard, and to ensure as a solid foundation for the future development of occupational resources, the Mental Health Division created, in the spring of 1989, the Working Group on the Spectrum of Occupational Resources for Individuals with Psychiatric Disabilities. Membership was composed of representatives from consumers, community agencies, mental health centres, acute care hospitals, Canadian Mental Health Association, Departemnt of Family Services, Provincial Community Mental Health Program, and the Mental Health Division. The purpose was to develop a proposed spectrum of occupational resources for children and adults with psychiatric disabilities and recommendations regarding prioritization of new occupational resources.

Due to significant barriers, in particular, the lack of a comprehensive data collection system in mental health, the Working Group limited the scope of this undertaking and developed a discussion paper that highlights principles related to service delivery, current trends in the literature and identifiable gaps in services for adults with severe psychiatric disabilities.

Regarding the needs of consumers for occupational resources, the Working Group was not able to find any evidence that consumer needs have ever been studied in a systematic fashion. Consequently, The Working Group recommends that assessments of consumer needs be conducted on an ongoing basis. Dr. William Anthony (1988), at The Centre For Psychiatric Rehabilitation in Boston, emphasizes that system planning must be driven by goals which come directly from the consumer population (e.g. satisfying jobs) and not be composed of predetermined services.

The major focus of the discussion paper is trends in the current literature and factors that should be considered in future program developments. Salient planning principles, principles of psychiatric rehabilitation, and innovative program models in employment, education and recreation are described.

As a result of the examination of past, present, and future trends and resources, as well as barriers to resource development, the Working Group created the following recommendations. The two purposes of the recommendations are to refocus thinking and to serve as a foundation for the planning of needed occupational resources.

RECOMMENDATIONS

I. Planning And Responsibility Centre - to be acted on immediately

- . Employment, education, recreation and ongoing supports be recognized as **important aspects in consumers' lives** and be **highlighted** in the planning and development of the mental health system.

The Mental Health Division, in conjunction with the Regional Mental Health Councils:

- . Have the **responsibility and authority** for the planning, operations, monitoring, and evaluation of all occupational resources. This planning and implementation authority is essential in order to ensure comprehensive, coordinated, regionally based, consumer directed programs are effectively delivered.
- . Develop a concrete **strategic five year plan** for all occupational resources.
- . **Strengthen relationships and resolve jurisdictional issues** with involved Government departments such as **Department of Education and Training** and **Department of Family Services**.
- . Address and resolve the **disincentives in the Social Allowance Program** that serve as barriers to employment for individuals with psychiatric disabilities.
- . Address and resolve the various **funding problems** of inter-governmental departments (eg. Family Services - V.R.D.P., S.A.R.; Mental Health Division; Federal Government - C.E.I.C.) which serve to fragment services and create barriers to employment.

II. Consumer Participation

- . Needs analyses from the consumer perspective be conducted on a regular basis to ensure that system planning and individual programs are driven by the goals which come directly from the consumers.
- . Mechanisms be established and utilized to ensure consumers play a key role in the overall planning, development, operation, and evaluation of regional and provincial occupational resources. To ensure consumers are enabled to participate and to acknowledge their expertise in the process, financial remuneration for their involvement must be a high priority.
- . Provincial standards clearly delineate that each agency that operates employment, education and recreation programs ensure consumer participation in the planning, operation, and evaluation of these programs.

III. Program Principles And Resources

- . The planning and development of all occupational resources must reflect and adhere to the principles of psychiatric rehabilitation and the following guiding principles (see figure 1 in document):
 - comprehensiveness of resources
 - coordination of resources
 - autonomy and empowerment of consumers
 - image enhancement of consumers
 - skill enhancement of consumers
 - community presence (ie. physical integration)
 - community participation (ie. social integration)
- . Whenever possible, employment, education and recreation programs be delivered in the relevant, real life environment where the skills are to be utilized.
- . Employment, education and recreation programs incorporate models that are supported in the current literature.
- . Ongoing support (ie. longterm financial and human resources based on individual need) for individuals in employment, education and recreation programs be recognized as a necessary component of service delivery and funded by the Province.

- . Provide a wide range of **real job options** to enable individuals to make vocational decisions as well as develop skills and supports as successful and satisfied workers and employees.
- . Mental Health Division take a **leadership role** in the coordination, facilitation and development of **training opportunities** that involve individuals working in employment, education and recreation programs for adults with psychiatric disabilities.

IV. Outcome Focussed Evaluation

- . Develop a **comprehensive data system** that includes the tracking of outcomes, and resources utilized in employment, education and recreation programs.
- . Individual employment, education and recreation programs conduct **outcome focussed evaluations** on a regular basis to ensure that the needs of participants are being met.

I. INTRODUCTION

The term, "occupation," refers to a task which engages a person's resources of time and energy. Human beings need to be "occupied" or involved with the world around them in various life roles such as worker, student, parent, homemaker, volunteer, etc. Persons with severe psychiatric disabilities have diagnosed mental illnesses that affect their ability to perform some tasks and roles. Consequently, these individuals need assistance to engage in life roles in a meaningful way, whether it be in the form of vocational pursuits (eg. as an employee) and/or avocational pursuits (eg. as a leisure participant, student, volunteer).

There is a general agreement that persons with severe psychiatric disabilities require a range of coordinated and basic community resources and supports in order to function within the community. (Stroul, 1989). In Manitoba, these resources, such as housing, peer and family support, rehabilitative services, crisis services, etc., are fragmented and underdeveloped. The particular area of occupational resources (re. employment, education and recreation) for persons with severe psychiatric disabilities has received little attention in the past and is in need of substantial improvements to meet the needs of the target population. In an effort to instigate positive changes in this area, this discussion paper focuses on occupational resources (ie. employment, education and recreation) in the past, present and future for Manitobans with severe psychiatric disabilities.

In November, 1988, The Minister of Health, the Honourable Donald W. Orchard, released the document, A New Partnership For Mental Health In Manitoba. This document highlighted the challenge of providing the full range of mental health services to Manitobans. In light of the new directions in mental health in the Minister's policy paper and to ensure a solid foundation for the future development of occupational resources, the Mental Health Division established a working group in October, 1989.

Terms Of Reference

The following Terms of Reference were developed for The Working Group on the Spectrum of Occupational Resources for Individuals With Psychiatric Disabilities in Manitoba:

Purpose

To develop a proposed spectrum of occupational resources for children and adults with psychiatric disabilities and recommendations regarding prioritization of new occupational resources.

Objectives

- 1) Identify target groups of adults and children and their needs in the occupational area ie. meaningful involvement in the community as worker, volunteer, student, leisure participant, etc.

- 2) Identify program/service models within the spectrum that meet the needs of identified groups; include program descriptions, criteria for eligibility, relationships between parts of spectrum.
- 3) Identify existing resources and resource gaps in relation to proposed spectrum.
- 4) Recommend types of resources from a provincial perspective that are most critical to be given high priority as new initiatives.
- 5) Provide recommendations on selected issues in regards to occupational resources as requested.

Membership

Membership was comprised of eleven representatives from consumers, involved community agencies in urban and rural Manitoba, mental health centres, acute care hospitals, Provincial Community Mental Health Program, Canadian Mental Health Association, Department of Family Services Vocational Rehabilitation Program, and Manitoba Health, Mental Health Division. The representative from the Mental Health Division served as chairperson of the Working Group.

It became apparent to the Working Group that there were significant barriers that would impede the group from meeting the established objectives in the Terms of Reference. Due to a lack

of a comprehensive data collection system in mental health, the available data was sketchy and collected in an inconsistent manner. No studies of any significance have been completed on the occupational needs of persons with severe psychiatric disabilities. In addition, the terminology in this field is used inconsistently thereby causing confusion, particularly in the area of employment.

Due to these barriers, the Working Group decided to limit the scope of the objectives and develop a discussion paper that highlights principles related to service delivery in the occupational areas of employment, education, and recreation, current trends in the literature and identifiable gaps in the current service delivery system for adults with severe psychiatric disabilities. Examination of these issues in relation to children and elderly persons was considered to be beyond the scope of this effort. The intent of this discussion paper is to achieve a reorientation in thinking and to serve as a foundation for the planning of needed occupational resources.

Methodology

A review of the relevant literature, consultations with knowledgeable individuals in the identified areas of interest and the distribution of a survey were the principal methods of investigation. The Working Group divided into the three subgroups on vocation/employment, education and leisure/recreation. Members participated according to their

areas of expertise and/or interest. Due to the reduced focus on the discussion paper, the Working Group relied primarily on knowledge of Working Group members and did not solicit feedback from an extensive range of groups and health care sectors and individuals.

II. NEEDS OF THE TARGET POPULATION

It is difficult to determine the number of people in Manitoba with chronic psychiatric disabilities due to the general lack of agreement in the literature of the definition of the term, "chronic", and a fragmented information system in the Province. However, based on statistical estimates in an article by Toews & Barnes (1986), a rough estimate of the number of individuals with chronic psychiatric disabilities in Manitoba that utilize the formal mental health system is 8,000 people.

The needs of consumers with chronic/severe psychiatric disabilities as identified by consumers and service providers have never been studied in a formal, systematic fashion in Manitoba. One of the recommendations of the Working Group is that assessments of consumer needs should be conducted on an ongoing basis. According to Cohen & Anthony (1988), the first question that mental health authorities need to ask is, "What do clients want and how can they best be helped to get what they

want?" Anthony indicates that experimental data confirms that people with severe psychiatric disabilities are similar to all of us and they want to work at satisfactory jobs, to live in improved housing and to develop friendships. He emphasizes that system planning must be driven by goals which come directly from the client population (eg. satisfying jobs) and not be composed of predetermined services.

In order to gain a flavor of the needs of consumers as well as resource problems and gaps, the Working Group conducted an informal survey with some service providers and participants in some existing mental health programs. In addition, relevant literature was reviewed, in particular, the report entitled, Injustice Walks Softly: Human Rights and Mental Illness by the Human Rights Committee of the Canadian Mental Health Association, B.C. Division (1989). The following points reflect the major themes that become apparent in this effort:

- There are too few programs in existence and the ones that exist are prescribed and predetermined, with little opportunity for tailoring programs to individual needs of participants.
- Many consumers attend a program once or twice and then express their dissatisfaction by dropping out of the program.
- There are limited choices for consumers in the type of training programs, jobs, and opportunities for learning and

advancement. As stated in Injustice Walks Softly: Human Rights & Mental Illness (1989, p. 9) regarding job opportunities, "We call them the 3 F's: food, filth, and filing".

- Consumers want meaningful compensation for the work that they do. They often work many hours at workshops with little or no wage.
- Programs tend to focus on disability and illness rather than ability and health. Low expectations on the part of program planners and service providers is one of the greatest barriers to individual progress.
- There is a need for follow-up support for consumers who are entering the workplace so that people have help not only to get a job but to keep a job.
- Consumers feel left out of the planning for programs and are rarely part of determining if their needs are being met.

III. THE PAST - AN HISTORICAL OVERVIEW

Due to a paucity of available documentation, it was not possible for the Working Group to track the historical developments in Manitoba in the occupational area in more than a cursory fashion. However, it is evident that there have been some major shifts in thinking in relation to the sites for service delivery (eg. community, institution) as well as the role of the patient/client/consumer. Today, service providers are being asked to help workers who are disabled as opposed to disabled persons who work. This implies that consumers are citizens with

human rights and that assistance should be provided in natural environments like the workplace, school and recreation facility.

In Manitoba, as in most other jurisdictions in Canada and North America, vocational, educational and recreational programs were established first in the provincial mental health centres. The mental health centres, with patient populations of 1,000 and more prior to the 1960's, were responsible for all the needs of the patients - housing, food, clothing, transportation, education, work, recreation, etc. The centres had their own farms (until 1950-1960's,) and workshops where patients did work tasks that were considered to be therapeutic and they received a nominal stipend for their work. In the 1990's, work, education and recreation programs are still offered to patients in the mental health centres and, as well, centre staff are actively involved in establishing programs in the community.

In 1961, the Vocational Rehabilitation for Disabled Persons Act (VRDP) came into being in Canada. This created financial incentives for the Province which led to the growth of vocational rehabilitation and sheltered workshops for disabled persons. Skills Unlimited in Selkirk became the first sheltered workshop in the community followed by Rehabilitation Industries in Brandon and others. In the late 1960's/early 70's, Vocational Rehabilitation Workers began to play a role in the training and placement of clients in work settings. At the same time, Community Mental

Health Workers were deployed to all the regions in the Province to provide counselling and supportive services to clients.

By the 1980's, there was some dissatisfaction with the existing vocational rehabilitation process as clients were progressing through a continuum of training and placement programs but few were actually achieving employment. The report by the Mental Health Working Group (1983) indicated that programming was oriented toward rudimentary vocational training and few mental health clients found it useful or relevant. There began to be increasing support for the principle of normalization and a focus on nonfacility based programming. In the last couple of years, there has been a dramatic decrease in the number of sheltered employees and an increase in work placements in community based businesses and organizations. In 1990, several new employment projects were created in Winnipeg to serve individuals with psychiatric disabilities.

The development of education and recreation resources was similar to that of employment resources. Prior to the 1960's, programs were, for the most part, located in the mental health centres, although some efforts were made to take patients to community based activities. In the 1960's, the Canadian Mental Health Association operated a drop-in centre in Winnipeg and Brandon for clients living in the community. By the 1970's, greater emphasis was being placed on using community facilities and organizations such as the YWCA, YMCA, YMHA, City of Winnipeg Parks and

Recreation and local churches became involved in programming. Dr. Clarkson (1973) indicated in his report to the Minister of Health and Social Development, that an essential component of a community oriented mental health program was supportive, recreational and social programs that integrate and not isolate the mentally ill from the mainstream of society. In the 1980's and 90's, self help groups have emerged as an important partner in health services and there has been movement toward consumer empowerment and consumer driven services. In regards to education resources, it seems that over time, they have remained within the jurisdiction of the Department of Education and have not been very accessible to adults with psychiatric disabilities.

IV. THE PRESENT - CURRENT OCCUPATIONAL RESOURCES IN MANITOBA

Due to the lack of a comprehensive data collection system and the lack of coordination among service providers and funders, there is no readily available documentation on current occupational resources for psychiatrically disabled individuals. Consequently, in order to obtain this information in an expedient fashion, a survey was conducted by the Working Group. The Provincial Regional Mental Health Coordinators, as well as members of the Working Group, were asked to consult with others to collect the information. To provide some parameters to this task, guidelines and a survey form were developed. (see Appendix 1). The results of the survey provide, at best, a general picture of the number and types of occupational resources at this time. It was not a major focus of the survey to address issues related to quality,

Suitability and comprehensiveness of the resources. However, an attempt was made to solicit information on intended program outcomes based on the following definitions that represent the current thinking in the literature:

EDUCATION - increasing competence in an integrated goal oriented setting.

VOCATIONAL/EMPLOYMENT - opportunity to earn a market wage in an integrated setting.

LEISURE - freely chosen activity for purposes of relaxation and enjoyment.

There were several major factors in the collection of the data that make it necessary to interpret the results with caution. The accuracy of the data is questionable as it represents the "best guesses" of the respondents based on the limited information available to them. The general findings of this survey are as follows (see Appendix 2 for details):

- . Over 75% of the 1,450 program participants live in Winnipeg and Brandon.
- . Winnipeg has programs that are predominantly segregated and designated for adults with psychiatric disabilities. In other regions, adults with psychiatric disabilities attend generic programs and/or programs that are designated for other target groups such as individuals with mental disabilities.
- . 30% of the participants in occupational programs in Winnipeg are involved in hospital day treatment programs that have primarily a clinical/treatment focus rather than rehabilitation.
- . The majority of the existing programs have a primary focus of vocation/employment (52.8%), followed by leisure (22.9%) and education (10%).

- . There are ten programs in Manitoba (with 229 participants) that are designated for individuals with psychiatric disabilities with a primary intended outcome of vocation/employment. Half of them are operated in segregated settings. Very few programs are offered in integrated settings with the intended program outcome being the opportunity to earn a market wage.
- . Due to lack of descriptive data, it is not possible to determine how many of the fourteen programs that have education as a primary outcome are actually provided in an integrated, goal oriented setting with a focus on increasing competency in students. It is likely that very few existing education programs meet this criteria.

In conclusion, it is clear from the survey information that the existing occupational resources are limited in number and program variety. Of the existing programs, very few of them meet the current trends in the literature on vocation/employment, education and leisure programs. It is important to note that since the completion of the survey, a number of new and innovative programs have become operational in Winnipeg. Perhaps this heralds a beginning of significant changes in the area of occupational resources.

V. THE FUTURE

1) Planning Principles

Significant trends in the mental health field have developed in the past few years. Some of the salient concepts now being focused on are consumer empowerment, physical and social integration of consumers, nonfacility based programming and ongoing support of consumers, to name a few. These trends highlight a shift and reorganization of the values and perspectives that underlie the mental health service system.

According to Cohen and Anthony, (1988), it is important to articulate the values that are the foundation of service system planning and this has been one of the major pitfalls in the past. The first task of the Working Group undertook was the development of a set of planning principles related to occupational programs so that these principles could serve as constant justification for moving the service system in a desired direction. The selection of these principles (see figure 1) was based on their particular relevance to the occupational area and their acceptance in the mental health literature as salient planning principles. (Mental Health Working Group, 1983; Cohen and Anthony, 1988; Trainor and Church, 1984). This is not intended to be an exhaustive list of principles. As well, it is important to note that these planning principles are generally consistent with the principles in the document, "Vision For The Future: Guiding Principles & Policies For Mental Health Services", that was released by the Mental Health Division of Manitoba Health in December, 1990.

2) The Psychiatric Rehabilitation Approach

Rehabilitation refers to the services and technologies that are made available to individuals with disabilities to assist them with coping with the impact of their disabilities. During the 1970's and 1980's, psychiatric rehabilitation gained recognition as a credible, and viable mental health approach which does not focus on the treatment and management of symptoms, but on the

FIGURE 1

**PRINCIPLES RELATED
TO SPECTRUM OF OCCUPATIONAL
RESOURCES**

**PRINCIPLES
RELATED TO
SERVICE SYSTEM
PROCESS**

- . COMPREHENSIVENESS - full range of well coordinated resources from institution to community including both formal and informal resources

- . COORDINATION - effective planning and organization of resources to ensure that consumers experience continuity across services and time.

- . AUTONOMY AND EMPOWERMENT - enhancement of consumer independence and control

- . IMAGE ENHANCEMENT - all efforts are made to present consumers in a positive and nonstigmatizing manner.

- . SKILL ENHANCEMENT - encouragement of consumers to acquire skills necessary to live, work and function in the community.

- . COMMUNITY PRESENCE - Physical integration that provides opportunities for participation in the mainstream of community life.

- . COMMUNITY PARTICIPATION - social integration that is the actual participation on mainstream of community life

RELATED CONCEPTS

- services provided locally
- least disruptive to consumer's lifestyle
- informal supports need to be recognized and present

- least disruptive to consumer's lifestyle

- based on client need
- consumer identified needs
- maximize consumer choice
- consumer involvement from planning to evaluation

- culturally relevant

- focus on increasing competency

- partnerships involving consumers, friends, families, service providers, individuals and organizations in community

**PRINCIPLES
RELATED TO
CONSUMER AND
SYSTEM PROCESS
AND OUTCOMES**

restoration of ability, functioning and skill development in a specific environment. (Anthony, Cohen and Farkas, 1990).

Rehabilitation is a two tiered process that focuses on 1) helping an individual to chose goals and objectives about places to live, learn and work, and 2) helping an individual learn skills and acquire the supports and resources necessary to achieve these goals. The basic principles of psychiatric rehabilitation, according to Farkas and Anthony (1989) are:

1. The primary focus of psychiatric rehabilitation is on improving the competencies of persons with psychiatric disabilities.
2. The benefits of psychiatric rehabilitation for the clients are behavioral improvements in their environments of need.
3. Psychiatric rehabilitation is eclectic in the use of a variety of techniques.
4. A central focus of psychiatric rehabilitation is on improving vocational outcome for persons with psychiatric disabilities.
5. Hope is an essential ingredient of the rehabilitation process.
6. The deliberate increase in client dependency can lead to an eventual increase in the client's independent functioning.
7. Active involvement of clients in their rehabilitation process is desirable.
8. The two fundamental interventions of psychiatric rehabilitation are the development of client skills and the development of environmental supports.
9. Long-term drug treatment is an often necessary but rarely sufficient component of a rehabilitation intervention.

There is a growing evidence to suggest that various components of psychiatric rehabilitation approach can significantly affect vocational outcomes. Critical among the components of an ideal vocational rehabilitative program is a program mission that integrates effective vocational rehabilitation practice with core principles of the psychiatric rehabilitation approach (Farkas and Anthony, 1989).

3) An Emerging New Paradigm For Occupational Resources

A paradigm shift is a reorganization of values, perspectives and meaning. It is a change in the status quo; a time when an accepted model is challenged by a new and different approach. According to Ridgway and Zipple (1990), this seems to be what is occurring, at least in part, in the field of mental health. Over the course in time, "the continuum of services" has been commonly accepted as the primary conceptual framework. The linear continuum has a number of settings with different levels of service. A client is matched to an appropriate setting based on his/her level of functioning. Once the client's level of functioning increases and the need for services lessens, the clients "graduates" and moves to a more normalized setting. The client may achieve independent status and is viewed then as requiring little or no formal services. There is growing discontent with the "continuum" framework as it is seen by many to have failed to develop services to meet the needs of consumers. (Ridgway and Zipple, 1990).

In order to provide readers with a vignette of what the emerging paradigm for occupational programs might be in the future, the Working Group developed a listing of likely features. (see figure 2). A central concept is the shift in the primary role from client/service recipient to participation in a range of normal life roles eg. worker/student/volunteer/leisure participant, etc. The Working Group has based this on trends and information in the literature (Ridgway and Zipple, 1990; Anthony, Cohen and Farkas, 1990; Donaldson, 1990) but has made some modifications for application to the area of occupational resources.

Figure 2An Emerging New Paradigm For Occupational Programs

<u>FROM</u>	<u>TO</u>
Segregated program settings	Physical and social integration - workplaces, schools, recreation facilities.
Client role	Normal roles eg. worker, student, volunteer, recreation participant
Transitional preparatory settings (i.e. train + train + remain)	In vivo learning in real settings (i.e. place + train)
Least restrictive environment, and personal independence (i.e. train + place + pray)	Most facilitative environment, and long-term supports (i.e. place + train + support)
Bricks and mortar (i.e. facility driven)	Services and supports and comit- ments to community based businesses and organizations
Staff driven	Consumer led
Staff as caretaker	Staff as inventor, broker, advocate
Clients into programs and slots	Flexible services tailored to the individual
Passive consumer role (eg. client is placed in a program)	Choose, find, get, learn, keep, change, upward/lateral movement, ambition.
No risk (risk avoidance)	Every day risk (risk management)

VI. INNOVATIVE PROGRAM MODELS

1) Vocation/Employment

In the last ten years, research findings have altered the thinking about vocational programming, particularly regarding the correlation of specific factors with vocational outcomes for people with psychiatric disabilities. Based on current information, employment models should be implemented so as to recognize or emphasize the variables that have been shown to positively relate to client outcomes (e.g., client supports, client skills, career counseling) and avoid the pitfalls of trying to predict participant performance with factors that are not correlated with outcome (e.g., psychiatric diagnosis, treatment history, subjective judgment of professionals). (MacDonald - Wilson, Mancuso, Danley and Anthony, 1989)

A common base of knowledge regarding operational principles has developed over the years from the experiences of various vocational programs that have incorporated psychiatric rehabilitation principles. Danley, Rodgers and Nevas (Farkas and Anthony, 1989) suggest that the following principles can be generalized to effective vocational rehabilitation practice for persons with severe psychiatric disabilities in any setting:

Effective vocational programs:

- . provide clients with the experience and assistance they need to make vocational decisions.
- . assist clients in developing the skills and supports they need to be satisfied and successful as WORKERS (eg. transitional employment, voluntary work).

- . assist clients in developing the specific credentials and technical skills of a preferred occupation.
- . assist clients in developing the skills and supports needed to be successful as EMPLOYEES in real employment settings.
- . have access to a network of environments or settings to enable participants to develop attitudes, knowledge and skills to perform adequately as a worker, as a member of an occupation, and as an employee.

Transitional Employment Programs (TEP) And Supported Employment

Two new and innovative program models are the Transitional Employment Program (TEP) and Supported Employment. Supported employment does not have a concise and universally agreed upon definition. As well, while these models are quite similar programmatically, controversy remains whether TEP is a part of supported employment or a separate model primarily due to its feature of being time limited. (MacDonald - Wilson, Mancuse, Danley and Anthony, 1989). Despite these discrepancies, these models both can be characterized as a "place-train" approach to employment in contrast to the traditional "train-place" approach used in sheltered workshops and traditional vocational training programs. This represents a challenge to the "job readiness" concept which has guided much of our service planning.

Traditionally, people who did not seem to have the skills for competitive employment remained in segregated settings to learn the skills until they were "job ready".

1) Transitional Employment Program (TEP)

Psychosocial rehabilitation centres in the United States (also referred to as the clubhouse model), such as Fountain House in New York City, are comprehensive, multiservice organizations in

which the philosophy of psychiatric rehabilitation is put into practice. (Anthony, Cohen and Farkas, 1990). TEP is a vocational training innovation that is currently in use in many psychosocial rehabilitation centres. A member of the centre is placed in an entry level job in a normal place of business. All placements are temporary (3 - 9 months), typically half time and are supervised by centre staff. A TEP is designed to develop self confidence, job references and work habits necessary to secure permanent employment.

ii) Supported Employment

In its simplest form, supported employment refers to the employment of a person with a disability which is achieved by providing ongoing job support at the worksite. Supported employment includes a number of group and individual industry - integrated work arrangements. In its ideal form, it involves paid employment for a fixed period of time each week; the work setting must be sufficiently integrated to allow, at least, equal opportunity for interaction with people not labelled disabled as with those who are; and supports must be available indefinitely.

Options include (Community Support Network News, 1989):

- The Enclave Model, (also called Work Stations) involves a separate area within a business where a group of persons perform work separate from the non-disabled employees of the business. They are supervised by an employee of the organization operating the work station rather than by the host business. The degree of contact with non-disabled persons varies depending on their location within the business. Work Stations typically involve assembly, packaging, and other kinds of piecework.

- . **The Mobile Crew Model**, involves a small group of disabled individuals with a supervisor/leader who work in a number of different locations in the course of a day or week. Janitorial and lawn maintenance are common duties for the typical crew.
- . **Individual Job Placement** (also known as **Job Coach** model and **Supported Competitive Employment**) provides disabled individuals with on-the-job training and support in regular jobs in the community. Support is ongoing and not time limited. (Community Support Network News, 1989). The **Choose-Get-Keep** approach developed by the Centre of Psychiatric Rehabilitation at Boston University is an operational framework for offering effective supported employment services to individuals with psychiatric disabilities. The goal of the **Choose** phase is the selection of an employment goal compatible with the participant's values and qualifications. The **Get** phase includes the job search and concludes with the acceptance of a job offer from an employer in a desired competitive setting. The **Keep** phase continues with supports and skill development provided as needed to help the employee be successful and satisfied in his/her chosen job. (MacDonald - Wilson, Mancuso, Danley, Anthony, 1989)

Other Work Arrangements And Options

In addition to the two models mentioned, there are numerous variations and supported work-type arrangements where a considerable degree of integration is achieved and where clients have the opportunity to do a real job and be valued by society as workers. Flexibility and the development of choices based on individual needs remain important in this process of developing the most effective approaches. (Community Support Network News, 1989).

Other work arrangements and terms that readers may encounter in this emerging area of employment are:

Work Cooperative - Business where disabled individuals work with non-disabled individuals and share in the profit reaped from the venture. In some cases, a support agency may act in an administrative consultant role.

Consumer Run Business - Small businesses that are owned by consumers and generally employ consumers.

Community Based Assessment and Training Partnership With Business - Assessment of work skills, work behaviour and generic job skills in real business/employment/industrial settings. Training to develop work adjustment skills, job related behaviors, generic job skills and specific job task skills in real business/employment/industrial settings.

Employment Support Groups - Mutual aid groups comprised of individuals seeking employment who provide support to each other in the process of finding, getting or maintaining jobs in the community.

Partnership With Business - Emphasis on working in conjunction with business (as opposed to independently) to develop job opportunities for individuals with disabilities. Service agencies and business or industry are viewed as partners to develop job training, industry referral and job placement.

Support For Future Directions In Employment

It is evident from the literature that supported employment and TEP are options that give greater vocational opportunities to consumers. The report by the Canadian Council on Rehabilitation and Work entitled, Supported Employment In Canada, provides extensive evidence of the potential and accomplishments of supported employment. This report does not, however, recommend the wholesale elimination of existing segregated vocational services such as sheltered workshops and vocational training centres. As supported employment programs continue to increase in number, quality and ability to support greater numbers of people, the Report states that segregated work settings such as sheltered workshops, will become increasingly devalued and obsolete.

Research on outcomes of supported employment is limited at present and there are some individuals who have some reservations about the purported outcomes (Supported Employment in Canada, 1989). Bond (1987) states that some vocational programs probably fall short of their expectations for a variety of reasons such as lack of a sound conceptual base, lack of cooperating employers, insufficient client base, inadequate funding and poor cooperation between mental health and vocational rehabilitation programs. He also identifies the characteristics of programs that have been successful in community placements as being strong leadership, passionate staff commitment to target groups, sustained involvement from business, and a community "employment agency" approach rather than "mental health" approach to vocational rehabilitation.

2) Education

One of the fundamental interventions of psychiatric rehabilitation is the development of consumer skills. Enhancing a person's capacity to cope with mental illness typically involves the learning of specific skills that are needed in order to function more effectively in his/her living, learning and working environments. Research has shown that persons with psychiatric disabilities can develop and/or enhance a variety of physical, emotional and intellectual skills regardless of their symptomology. When these skills are properly integrated into a rehabilitation program that supports their use, they can have a

significant impact on the client's independent functioning in the community (Farkas And Anthony, 1989).

The formulation of "problems" as skill deficits in psychiatric rehabilitation implies that the impediments can be overcome through education. Skill development through education, however, does not discount the importance of the environment-support component of psychiatric rehabilitation. Rather, it emphasizes the normalization of skill development in non-stigmatizing, natural, educational environments while still incorporating the support component. The clubhouse model, storefront settings, and more recently, educational settings are being utilized to provide more natural settings.

Programs have emerged in the last few years that stress a learning environment as a context in which the psychiatric rehabilitation approach is offered. An effective psychiatric rehabilitation program in an educational context would include a mission to teach skills in an education setting to psychiatric disabled clients and to provide support for the use of those skills that will assist them to function more independently in their environment of choice (Farkas and Anthony, 1989).

Innovative education programs have developed in the USA in traditional (eg. mental health centres) and nontraditional (eg. university campus) settings. The key concept is that the primary intervention is delivered within an education rather than a treatment context. The learning environment emphasizes the role

of student and teacher that are common and familiar to the general population.

Social skills training (SST) is an intervention that has been described a significant amount in the literature. It addresses specific deficits in social skills in consumers by using a systematic, behavior modification approach. Programs are usually quite intensive, involving individuals for three hours or more per week and often last six months or longer. The programs are provided in various community based settings as well as hospitals. According to Anthony, Cohen and Farkas (1990), social skills training holds most promise as a specially targeted component of a comprehensive program. The methodology of SST can be integrated with the skills teaching component of a psychiatric rehabilitation intervention.

Research indicates that acquisition of skills is not a major problem for persons with psychiatric disabilities. They can and do learn skills when effectively taught. The problem is more in the application or performance of skills in a relevant environment. A consumer's ability to generalize skills to new environments needs to be carefully examined and developed. In order to maintain motivation, relevant coursework is essential to develop in relationship to the stated goals of the students in the program (Anthony, Cohen & Farkas, 1990). Teaching a person to cook is only relevant if the student has access to equipment

and will be making meals. While educational goals vary based on individual need and circumstances, some examples might be to develop a career plan, to attend a skill based post secondary program, to learn specific and relevant life skills, and to attend an adult continuing education course on a topic of personal interest. To maximize generalization of skills, it is important, as well, that opportunities for practicing the new skills are provided where they will be used.

Models Of Supported Education

In the last five years or so, supported education has developed in the United States to the extent that three models or approaches to the provision of supported education have emerged. The definition of supported education, adapted from the definition of supported employment, is education in an integrated setting (a) for individuals with severe psychiatric disabilities for whom post-secondary education has not traditionally occurred or (b) for individuals for whom post-secondary education has been interrupted or intermittent as a result of a severe psychiatric disability, and who, because of their handicap, need ongoing support services to be successful in the education environment. (Community Support Network News, February 1990).

The three supported education models as reported in Community Support Network News in February 1990 are:

- i) **SELF-CONTAINED CLASSROOM** - This model provides a specific curriculum which is offered in a classroom setting at a postsecondary site. As students complete the curriculum, they are mainstreamed into the academic environment and continued support is provided by staff.
- ii) **ON-SITE SUPPORT** - In this model, participants are regular students but they receive support from campus staff that is very similar to the services that are often provided to physically disabled and learning disabled students. The purpose is to develop and implement a community support program on college campuses for students with severe mental illness in order to help them achieve their educational goals. The staff provide support and teach the skills necessary for the students to participate successfully in "mainstream" education programs.
- iii) **MOBILE SUPPORT** - This model is part of other programs which have as their main function the traditional provision of mental health services. Within these programs, there is a recognition of the importance of education in the rehabilitation and community integration process. Consequently, they prepare individuals to attend post secondary sites and provide supports as students attend the campus of their choice. The unique feature of this model is that it can be operationalized from an institutional or community based setting.

The provision of educational programming to individuals with psychiatric disabilities is not a new idea. The early development of this idea has occurred in environments commonly viewed as treatment and rehabilitation settings. What is innovative and emerging is the model of a rehabilitation program in an educational setting. In the future, rather than bringing the consumer to the treatment/ rehabilitation settings, it may be that practitioners and consumers are brought to educational settings where consumers would experience themselves more naturally as learners.

3) Recreation/Leisure

Recreation and leisure activities are a vital part of everyone's life. These activities have a significant potential to develop life skills, create cohesive communities, function as a therapeutic intervention, fill voids in people's lives and promote and maintain health lifestyles. The field of recreation is changing and expanding in response to societal changes. As recreation becomes increasingly more important to the general population, there are opportunities to integrate persons with psychiatric disabilities into the community at large. For individuals, such as a considerable number of people with psychiatric disabilities, who are unable or have chosen not to work, recreation plays a more significant role in their lives.

Issues related to segregation and integration are important to examine in the context of recreation, as well as the other program areas described in this paper. According to Hutchinson and Lord (1979), a spectrum of experiences exists from most restrictive to least restrictive in recreation arrangements that are either segregated, physically integrated (but socially segregated) or socially integrated. There is no one right place on the spectrum for an individual to be participating. A person may find that he/she could be participating in various experiences in three or four different areas of the spectrum simultaneously, with each one meeting different needs and interests at that particular time. For example, a man who lives

in an institution frequently plays cards with other residents, is an example of segregation. He also attends an evening swimming program at the community pool with six other people from the institution for special skill upgrading classes. This is an example of physical integration. Finally, he attends in elementary ceramics class once a week at the adult education centre in the community. He goes on his own and is given support at the class by a fellow participant during this socially integrative experience.

The decision as to where on the spectrum of segregated/integrated recreation experiences a person participates at any one time is dependent upon a number of factors such as personal characteristics (eg. needs, interests, skills, choices, experience) and program factors (eg. availability, quality of leadership, nature and quality of experience). The goal would be for an individual to chose to participate in the least restrictive alternative after examining the above mentioned factors (Hutchison and Lord, 1979).

The topic of supports for individuals with psychiatric disabilities appears a great deal in the current literature, particularly in the field of psychiatric rehabilitation. Supports are defined in psychiatric rehabilitation as **persons, places, things and activities** external to an individual that make it possible for him or her to succeed in an identified

environment (Farkas & Anthony, 1989). A combination of supports specific to the needs of the individual, are frequently needed to assist persons with psychiatric disabilities to become involved in new environments, such as an unfamiliar recreation program. Generic community recreational facilities, become much more "user friendly" when people supports, such as volunteer buddies, receptive program staff, friends and/or family, are involved in the activities. Psychosocial clubhouses and self help groups are examples of "place" supports and are specialized resources that assist in meeting social and recreational needs of consumers. Program fee assistance or subsidization is a needed support for those individuals with limited incomes.

The important factor in recreation/leisure is the control the participant has over the choices made which are specific to his/her interests and needs. Barriers to recreation participation are being broken by providing opportunities, choices and individual support (Brophy, 1990).

VII A SUGGESTED SPECTRUM OF OCCUPATIONAL RESOURCES

The following is a suggested spectrum or array of occupational resources based on the current literature and inclusive of institutional and community based resources. It is intended to provide the reader with "a menu" of some suggested occupational resources. Linear movement of consumers through a continuum and permanently out of the system is not implied here but rather that

consumers may need varying kinds of support and opportunities at different points in their lives.

Vocation/Employment

- * TEP or transitional employment programs that place participants in community employment situations where they receive time limited training with assistance in part-time work.
- * Supported employment opportunities for groups of individuals to work on mobile work crews and work enclaves.
- * Career counselling programs to help individuals with psychiatric disabilities make vocational decisions.
- * Competitive employment placement services delivered by specialists working with individuals with psychiatric disabilities.
- * Supported competitive employment for individuals to do on-the-job training and receive support for an indefinite period on regular jobs in the community.
- * Time-limited community based assessment and training for individuals with psychiatric disabilities in business settings.
- * Employment support groups and job clubs for consumers adjusting to competitive employment or other new work situations.
- * Consumer run businesses.
- * Work cooperatives.
- * Sheltered employment providing paid work experience to workers with psychiatric disabilities.

Education

- * Educational upgrading programs in classrooms in educational settings with remedial teaching in basic high school level subjects such as English and mathematics along with career counselling, etc.
- * Life skills and social skills training programs including household management, personal management (eg. problem solving, assertiveness, coping with stress), transportation, parenting, dealing with crises, financial management, etc.

- * Psychosocial clubhouses with opportunities to develop or regain prevocational and vocational skills.
- * Psychoeducational programs for families of consumers in which support and information is given to reduce family stresses.
- * Access and support to participate in community education programs such as adult continuing education courses.
- * On-site support and mobile support services for individuals participating in post-secondary courses on educational campuses.
- * Programs in residential settings and hospitals to help individuals develop initial prevocational experiences at these sites so that they can begin to become interested in vocational and educational goals as well as seek to make use of other services.

Recreation/Leisure

- * Use of general community recreational resources with supports (eg. people, places, things, and activities) as needed.
- * Self help groups that may include social/recreational events, educational sessions, drop-in centres, advocacy, peer counselling, etc.
- * Psychosocial clubhouses where individuals with psychiatric disabilities can be involved as members in the leisure, social, and work activities of the clubs.
- * Therapeutic social clubs which provide structured activities during the day, evenings, weekends and holidays. These clubs provide sheltered social experiences to individuals with psychiatric disabilities to reduce feelings of isolation and improve interpersonal skills.
- * Upgrading experiences in institutional programs aimed at having patients eventually leave (initially for short time periods) the segregated environment, and live in the community.

VIII BARRIERS TO THE DEVELOPMENT OF INNOVATIVE AND EFFECTIVE OCCUPATIONAL RESOURCES

There are a host of significant impediments or barriers to the development of effective and innovative resources in the areas of employment, education and recreation. For the purpose of this paper, the Working Group classified the barriers as system, program and personnel barriers. System barriers are impediments to organizing and funding the people and programs which deliver these services; personnel barriers are those current limitations of the people who are service providers; program barriers are impediments to developing and using effective techniques and procedures within a program setting. Only the most salient barriers are listed as identified in the literature and by individuals who have been consulted. It is interesting to note that the listed barriers are very consistent with those that were identified by the participants of the Manitoba Supported Employment Network at the fall retreat in Winnipeg in November, 1990.

System Barriers

- Historical disinterest and lack of attention of the mental health system to employment, education, and recreation services and outcomes.
- Existing funding structures are an administrative nightmare thereby inhibiting innovation and the testing of new models in employment, education and recreation areas.
- Lack of meaningful involvement of consumers in the planning, development, implementation and evaluation of the mental health system and programs.

- * Inadequacy of social assistance benefits as well as financial disincentives for those individuals who wish to no longer receive social assistance and earn a wage.
- * Lack of a coordinated data system in general in mental health as well as common data between mental health and vocational rehabilitation program areas.
- * Lack of coordination between levels of Government, Government departments (eg. Health, Family Services, Education) and health sectors (eg. hospitals, community programs).
- * Need for more focussed direction and leadership in the areas of employment, education and recreation.
- * Lack of clarity in terminology in the occupational resources area which causes confusion and ambiguity.
- * Negative attitudes and misinformation on the part of employers and the community in general toward individuals with psychiatric disabilities.

Program Barriers

- * Lack of start-up dollars for new program initiatives.
- * Lack of experts for program consultation in areas of employment, education and recreation.
- * Lack of funding mechanism and dollars to provide follow-up support to consumers.

Personnel Barriers

- * Low expectations of consumers on the part of service providers and program planners.
- * Existing mental health service providers often understand the need for support for consumers but lack the knowledge, skills and time necessary to provide it.
- * Service providers need to be assisted to expand their expertise in psychiatric rehabilitation.

In summary, the area of occupational resources for individuals with psychiatric disabilities in Manitoba has suffered from a lack of attention and focussed efforts, poor communication and collaboration between involved parties and the lack of trained personnel with expertise in the areas of employment, education and recreation.

IX. RECOMMENDATIONS FOR FUTURE DEVELOPMENT IN MANITOBA

In the last decade in North America, significant changes and trends have developed in areas of employment, education and recreation for adults with psychiatric disabilities. For example, developments have occurred in psychiatric rehabilitation, consumer empowerment, employment and educational opportunities, nonfacility based programming and ongoing support that are tailored to individual needs. Central to these changes is the shift from the primary role of client/service recipient to the life roles of worker, student, leisure participant, etc.

Recently, in 1990, a few projects in employment and education were created that incorporated some of the innovative concepts described in this paper. By and large, the occupational resources for adults with psychiatric disabilities in Manitoba remain underdeveloped and focussed on traditional program concepts. The following recommendations are offered to achieve a reorientation in thinking and to serve as a foundation for the planning of needed occupational resources.

I. Planning And Responsibility Centre - to be acted on immediately.

- Employment, education, recreation and ongoing supports be recognized as important aspects in consumers' lives and be highlighted in the planning and development of the mental health system.

The Mental Health Division, in conjunction with the Regional Mental Health Councils:

- . Have the responsibility and authority for the planning, operations, monitoring, and evaluation of all occupational resources. This planning and implementation authority is essential in order to ensure that comprehensive, coordinated, regionally based, consumer directed programs are effectively delivered.
- . Develop a concrete strategic five year plan for all occupational resources.
- . Strengthen relationships and resolve jurisdictional issues with involved Government departments such as Department of Education & Training and Department of Family Services.
- . Address and resolve the disincentives in the Social Allowance Program that serve as barriers to employment for individuals with psychiatric disabilities.
- . Address and resolve the various funding problems of intergovernmental departments (eg. Family Services - V.R.D.P., S.A.R.; Mental Health Division; Federal Government - C.E.I.C.) which serve to fragment services and create barriers to employment.

II. Consumer Participation

- . Needs analyses from the consumer perspective be conducted on a regular basis to ensure that system planning and individual programs are driven by the goals which come directly from the consumers.
- . Mechanisms be established and utilized to ensure consumers play a key role in the overall planning, development, operation, and evaluation of regional and provincial occupational resources. To ensure consumers are enabled to participate and to acknowledge their expertise in the process, financial remuneration for their involvement must be a high priority.
- . Provincial standards clearly delineate that each agency that operates employment, education and recreation programs ensure consumer participation in the planning, operation and evaluation of these programs.

III. Program Principles And Resources

- . The planning and development of all occupational resources must reflect and adhere to the principles of **psychiatric rehabilitaiton** and the following guiding principles (see figure 1 in document):
 - comprehensiveness of resources
 - coordination of resources
 - autonomy and empowerment of consumers
 - image enhancement of consumers
 - skill enhancement of consumers
 - community presence (ie. physical integration)
 - community participation (ie. social integration)
- . Whenever possible, employment, education and recreation programs be delivered in the **relevant, real life environment** where the skills are to be utilized.
- . Employment, education and recreation programs incorporate **models** that are **substantiated in the current literature**.
- . **Ongoing support** (ie. longterm financial and human resources based on individual need) for individuals in employment, education and recreation programs be recognized as a necessary component of service delivery and funded by the Province.
- . Provide a wide range of **real job options** to enable individuals to make vocational decisions as well as develop skills and supports as successful and satisfied workers and employees.
- . Mental Health Division take a **leadership role** in the coordination, facilitation and development of **training opportunities** that involve service providers working in employment, education and recreation programs for adults with psychiatric disabilities.

IV. Outcome Focussed Evaluation

- . Develop a **comprehensive data system** that includes the tracking of outcomes, and resources utilized in employment, education and recreation programs.
- . Individual employment, education and recreation programs conduct **outcome focussed evaluations** on a regular basis to ensure that the needs of participants are being met.

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APPENDIX I

GUIDELINES FOR COMPLETION OF SURVEY FORM ON OCCUPATIONAL RESOURCES (MAY/90)

1. Excluded from this study are programs in community residential facilities and inpatient facilities of general hospitals and mental health centres.
2. List programs with primarily a REHABILITATIVE focus as opposed to a focus on clinical or mental health promotion/prevention.
3. Region & Local Areas - List both region and local area/urban center where program is located eg. Westman - Souris.
4. Designated/Other Target Group/Generic (D/OT/G) - Indicate if program is (a) specifically designated for psychiatric disabled individuals or (b) designated for another target group (eg. mentally handicapped) but is being utilized by psychiatrically disabled individuals as well or (c) generic in nature and utilized by general public (eg. YM/YWCA).
5. Age Range - Specify the approximate age range of participants in program (eg. 18-25 years).
6. Intended Program Outcomes - Indicate one or more intended program outcomes by using the following key:
 1. primary intended outcome
 2. secondary intended outcome
 3. tertiary intended outcome

Definitions of intended outcomes are as follows:

Education - increases competence in an integrated goal oriented setting.

Vocation/Employment - opportunity to earn a market wage in an integrated setting.

Leisure - freely chosen activity for purposes of relaxation and enjoyment.

7. Number Of Psychiatrically Disabled Participants In 198/90 - Indicate the number of individuals who participated in the program in 1989/90. Estimate this if you can not obtain actual figures.
8. Comments - (i) Some programs will not comfortably fit the definitions that we have given for education, vocation/employment and leisure, particularly in relation to the concepts of an integrated setting and the opportunity to earn a fair market wage. Please indicate your opinion regarding any discrepancies between these definitions and the actual problem. (ii) Any other comments you wish to make regarding a particular program.

1. primary outcome
2. secondary outcome
3. tertiary outcome

- D - designated program for psych disabled
- OT - program for other target group
- G - generic program

[illegible]

APPENDIX 2

FINDINGS OF SURVEY ON CURRENT OCCUPATIONAL
RESOURCES FOR PSYCHIATRICALY DISABLED ADULTS
IN MANITOBA (June 1990)

- 1) NUMBER OF PROGRAMS IN PROVINCE = 70
- 2) NUMBER OF PARTICIPANTS IN PROVINCE = 1450

3) NUMBER OF PARTICIPANTS BY REGION

Region	Avg. Number Indivs. per Session	Percentage
Winnipeg.....	763	52.6
Central.....	37	2.6
Thompson.....	10	0.7
Norman.....	107	7.4
Parklands.....	9	0.6
Westman.....	359	24.7
Interlake.....	90	6.2
Eastman.....	75	5.2
TOTAL	1450	100.0

Appendix 2...cont.

4) PROGRAMS BY REGION

REGION	Designated	Other Target	Generic	Design + Other target	Row Total + percent
Winnipeg	17		1	2	20 28.6
Central		4	1	1	6 8.6
Thompson				1	1 1.4
Norman	2	4	11		17 24.3
Parklands		2	1		3 4.3
Westman	4	1	2		7 10.0
Interlake	4	1	3		8 11.4
Eastman		3	5		8 11.4
Column Total	27	15	24	4	70
Percentage	38.6	21.4	34.3	5.7	100.0

5) NUMBER OF DESIGNATED PROGRAMS WITH "VOCATION/EMPLOYMENT" AS PRIMARY INTENDED OUTCOME = 10

AVERAGE NUMBER INDIVS. PER SESSION SERVED IN THOSE PROGRAMS
= 229

Appendix 2...cont.

6) PRIMARY INTENDED OUTCOME: ALL PROGRAMS

Primary Intended Outcome	Number	Percentage
Vocation/Employment	37	52.8
Vocation/Employment and Leisure	4	5.7
Education	7	10.0
Leisure	16	22.9
Not Reported	6	8.6
TOTAL	70	100.0